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THE BRITISH JOURNAL OF DERMATOLOGY

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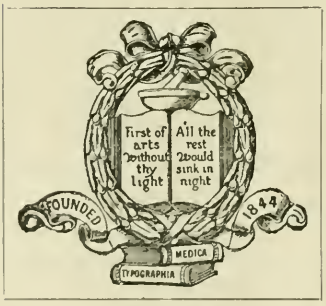

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THE BRITISH
JOURNAL OF DERMATOLOGY.
NOVEMBER, 1908.

THE TREATMENT OF SYPHILIS.

By MAJOR H. C. FRENCH, R.A.M.C., Woolwich.

The editor of the *British Journal of Dermatology* has kindly honoured me by a request to write my experience of the treatment of syphilis. I think this wish is best met by a *resumé* of actual practice at the Royal Herbert Military Hospital, Woolwich, a large garrison, where I have been working for the past three years. It may also prove of interest to give a short history of the underlying factors which have been chiefly instrumental in causing a very marked reduction of syphilis within the British Army in recent years. Prophylaxis by medical treatment necessarily reacts on civil communities, and a reduction in the amount of disease in the Army means the lessened incidence of syphilis in civil communities, whilst the converse holds equally true.

The time to commence mercury in the treatment of syphilis is a crucial question and involves many considerations. Mr. Jonathan Hutchinson states: "If the patient has never had syphilis before, whatever are the characters of any primary sore which he may exhibit, the chances are two to one that the sequel will prove that it contained the germs of true syphilis." If this were true we would be justified on a probability of averages in prescribing the drug at once in every case of venereal sore. In the British Army, in England and abroad, where numerous cases of venereal sore come under early notice, soldiers are first treated in hospital. Commencing, however, from September, 1903, men, on discharge from hospital, remain

under continued observation. Exact diagnosis is thus more feasible than in civil life where cases are wholly treated as out-patients, where their actions are uncontrolled, and where they commonly communicate disease to others. I conducted an investigation in 1904, at Cairo, amongst 200 consecutive in-patients with venereal sores. The cases on discharge from hospital were kept under prolonged observation. There were forty-five cases of syphilis, that is, a relative frequency of 3·5 non-infecting chancres (soft chancres) to 1 of syphilis.* Previous and present experience and carefully collected military statistics support this view. Naturally it is a hard point to estimate accurately, as soldiers, more especially in England, may resort to civil practitioners and chemists in order to avoid loss of pay by reason of admission to hospital. No doubt many cases are only sent to Mr. Hutchinson when there is a strong probability of syphilis. I think, therefore, on the evidence, that the probability of chances in a large number of cases is about three to one against syphilis. The relative frequency, however, is of slight value in arriving at a correct diagnosis, the nature of the chancre and the condition of the adjacent lymphatic glands being of the utmost importance as regards treatment. In the foregoing investigation at Cairo, which I have since verified at Woolwich in many hundreds of cases, induration in some degree was almost invariably present at some time in syphilitic chancres, although it need not necessarily be obvious on the occasion or occasions on which the medical man happens to see the case, since it may have disappeared, or may not have developed. The induration should be felt with the fingers. It is rapidly dissipated by adequate treatment with mercury, and is much more marked in some cases, especially on the tense corona glandis. It is commonly less marked and frequently overlooked on the frænum. In the soft substance of the glands or on the external skin of the penis it may be absent, or not appreciable (parchment induration). Induration was, with rare exceptions, also present in the proximal lymphatic glands in the primary stage, and these glands were usually bilaterally enlarged as the rash came fully out. There was either a discrete bullety enlargement or hyperplastic non-suppurating mass (bubo), which rarely ended in suppuration in the case of syphilis, and the amygdaloid or bullet nature of the individual

* *Syphilis in the Army*, 1907, John Bale, Sons & Danielsson, Appendix I.

glands could be later made out as the mass slowly subsided under mercurial inunctions. These hyperplastic mattings in the groin usually resulted from concealment, irritation, and active exercise in the chancre stage. In the case of non-infecting sore, suppurating buboes rapidly resulted from concealment or neglect in the initial stages. The demonstration of *Treponema pallida* of Schaudinn in the chancre is proof of syphilis, but Ducré's bacillus, the cause of non-infecting chancre, might also be present in a mixed syphilitic infection. The condition of pseudo-chancre induré first described by Fournier, in Paris, is a condition where induration is stated to occur in a chancre which is non-syphilitic. The fact of the nearest lymphatic glands being normal will usually clear the diagnosis. It is feasible that in some instances such a condition may occur in a person already the subject of constitutional syphilis, being, in fact, a local inflammatory reaction. Although I have in very rare instances seen conditions that might be so described, yet from their extreme rarity I prefer to suspend judgment for a while. In the light of recent observation I am of opinion that induration in a chancre (Hunterian chancre) or in the resulting cicatrix is the most valuable clue we have to the recognition clinically of early syphilis, especially in association with bullet glands. If, therefore, we can properly exclude a condition such as the above, it considerably advances our knowledge of a difficult subject. Acquired syphilis on the genitals is nearly always accompanied with ulceration, and in certain phases of the ulcer it is quite impossible from the local appearance to diagnose syphilis. Induration may occur early or late in the base or edges of the ulcer, but when slight may escape our vigilance. In the case of artificially inoculated syphilis on the skin by vaccination or otherwise, a papule is the usual initial lesion, and in rare instances I have seen such occur on the glans penis. The vast majority of syphilitic ulcers, however, probably come under the category of so-called "mixed" infections, the ulceration, purulent products, and in phagedæna the active necrosis or even sloughing of tissue being mainly dependent on accidental factors, such as neglect, exercise, and the irritation of a tense prepuce. It can therefore be readily understood why suppurating buboes occur in connection with syphilis, and in fact they are by no means rare. Further, I also quite frequently see a true attack of gonorrhœa later followed by syphilis,

the patient first developing a chancre after some time in hospital. Scars on the penis are very dangerous criteria on which to diagnose syphilis, as the largest scars are often due to a loss of substance in a non-infecting chancre with phagedæna. Scars on the penis without any collateral evidence are not infrequently accepted as proof positive of syphilis by writers on nervous diseases, but statistics compiled on such slender data should be rejected. Both non-infecting and infecting chancres may be indolent in healing, and the incidence of appearance after connection is frequently a doubtful criterion on which to base a diagnosis, since truthful histories are hard to elicit and syphilitic chancres are commonly due to "mixed infections." The time limits were worked out many years ago on experimental or vaccinal inoculations, being ten to forty days, with an average of twenty-five days. Although syphilitic chancres are in the large majority of instances single, yet the non-infecting variety of chancres also frequently appear single, more especially in hospital, where auto-inoculation has been prevented by aseptic or antiseptic treatment. Amongst patients presenting multiple sores, balanitic excoriations, or abrasions, one of these may later prove to be syphilitic, or a ring of induration may develop from the whole excoriated surface. Urethral chancres usually occur at the meatus with urethral discharge, and may prove to be erosive in nature; induration occurs in most cases as the ulcer heals, and both chains of inguinal glands are usually implicated. Erratic chancres are very rare, and are almost invariably syphilitic. The most common situations are the lip and tonsil. I have seen one, however, on the centre of the forehead, and one on the calf of the leg. The nearest lymphatic glands are usually typical. Metchnikoff claims to have successfully inoculated the *Treponema pallida* and prevented syphilis by the early application within twenty-four hours from contagion of an ointment of calomel 10 parts and lanoline 20 parts. The use of soap or vaseline prior to coitus and washing with any antiseptic lotions immediately afterwards are also of great prophylactic value and have been long recognised. Any oily substance would tend to block the minute orifices by which the micro-organisms gain an entry, and also tend to lessen the risk of abrasions caused by coitus. Cauterisation rapidly converts an unhealthy sore into a healing ulcer, stops phagedæna, tends to limit bubo formation, and expedites recovery. The application of a caustic does not in reality alter the nature of an

infecting sore, and the condition of the adjacent lymphatics nearly always comes to our rescue. Further, a rash occurs in syphilis, whether the chancre is cauterised or not. I consider that non-infecting sores (soft chancres), if unhealthy looking or discharging, should be locally touched with pure carbolic acid, which is comparatively painless, on admission and every third day, according to the indication of the particular case. Chancres, unless phagedænic, need not be touched if obviously indurated, or undoubtedly syphilitic, or if they bleed profusely before and after touching, since such bleeding, as in simple inflammation, is a sign of commencing resolution. A perchloride of mercury dressing (1 in 2000) is useful, and iodoform is very valuable. Balanitic sores or abrasions often heal better with a solution of Argent. nitratis gr. ij to the ounce on lint. If phimosis co-exists, hot baths, and packing under the foreskin with carbolised gauze, and stretching with phimosis forceps may suffice; if not, operation is necessary. Primary circumcision, except in phimosis associated with gonorrhœa, is, I think, bad practice, as the whole wound commonly becomes infected, and the duration in hospital may extend to three months. It is best to make a dorsal incision of the prepuce, let the wound heal, and treat the syphilis. When the wound has healed and the thickening subsided a secondary circumcision should be done. Buboes in the groin are usually due to irritation caused by the chancre rubbing against the prepuce or clothes, and hence exercise should be avoided in the early stages. Suppurating buboes should be incised and scraped at an early date, as otherwise they are apt to burrow extensively, especially in cachectic subjects, or in hot climates, and so necessitate extensive operation accompanied by profound debility. Many writers have advised the withholding of mercury in cases of phagedæna. I admit that caution and judgment are necessary. Local treatment, free exposure, prolonged baths, diet, and stimulants ordinarily suffice for phagedænic ulcers, except when the nearest glands are typical of syphilis, when mercurial inunctions should be used. The two common causes of phagedæna are phimosis, congenital or inflammatory, and neglect by the patient. Sloughing of the soft tissues rapidly occurs owing to the highly infective pus being pent up. Mr. Jonathan Hutchinson states that phagedæna only occurs in syphilis. It occurs, however, in both non-infecting and infecting chancres. I have collected a large series of cases in both.

A lowering treatment has unquestionably a bad effect, whether dietetic or medicinal, especially if mercury is given when syphilis is non-existent.

The grave effects of syphilis are largely due to the original intensity of infection, to personal susceptibility to the action of the virus from lowered general health, from whatever cause arising, to racial susceptibility, to intemperate habits, to the neglect of early treatment, and to the injudicious use of mercurial preparations. The primary and early secondary stages run a definite course, and no line of treatment can absolutely prevent the evolution of manifestations, but good treatment in hospital in the early stages markedly ameliorates the general blood condition and better guards against later relapse and tertiary manifestations. Kaposi says that "treatment in the primary stage disorders the evolution of the symptoms of infection and makes tertiaries more frequent." In my experience it is only when treatment is not given because the syphilis is not recognised, when mercury is injudiciously administered, especially in the form of insoluble grey oil, or when remedies are too early suspended, that tertiaries become frequent. In cases of malignant syphilis, however, which are fortunately rare, tertiary manifestations may occur within six months, concurrently with the initial secondary rash. In the case of venereal sores, which do not present the classical features of syphilis, administration should, I think, be deferred until two of the accepted signs of syphilis are present, namely, evident induration of the chancre, which is present at some period in probably 90 per cent. of infecting chancres, and indurated enlargement of the proximal lymphatic glands. These are most valuable indices to syphilis before the occurrence of rash or other symptoms. I always treat clear cases of infecting chancre with a course of forty inunctions of ung. hydrarg. before the rash begins and then wait for further symptoms, which occur in a modified degree in the case of syphilis. It is frequently stated as a justification for withholding mercury in the primary stage (*i. e.* before rash appears) that the evolution of secondary symptoms is thereby unduly delayed. I do not think that this is appreciably so, although the local evidence of induration in the chancre or lymphatic glands is rapidly dissipated, but I do think that the ensuing disease is considerably modified by a course of forty inunctions in the primary stage, that the general health suffers less with the

later advent of the rash and sore throat, and that relapses, tertiaries, and nervous lesions are subsequently much less. I exclude malignant syphilis from this category. In those fortunately rare cases where the induration of the chancre or lymphatic glands is not at some time apparent, it is wiser to wait for further evidences of constitutional syphilis, such as rash, sore throat, mucous patches, alopecia, etc., which ordinarily occur within four months or so of infection. If syphilis is definitely diagnosed the patient is then more willing to undergo the prolonged treatment which is essential to cure. This latter consideration more especially applies to civil practice, as the patient usually prefers a definite diagnosis. Personally, I decline to give a diagnosis in doubtful cases under four months, and experience demonstrates the wisdom of reticence. The early, non-infiltrated, roseolar, erythematous syphilide (also called rubeolar syphilide in that type of it which resembles measles), which is very common in syphilis, may only last four days to one week, and is commonly overlooked by both patient and medical man. Owing to the naturally evanescent nature of such rashes various new forms of treatment have from time to time been unduly lauded. After the first nine months external manifestations are rare both in treated and untreated syphilis, which shows the active part played by Nature, apart from our remedies, in the process of repair. In an experience of over a thousand cases thoroughly treated in hospital in the chancre stage by mercury, diet, and every resource at present known to the profession, secondary symptoms, *i. e.* rash, sore throat, mucous patches regularly occurred in some degree. The evolution of these symptoms could not with certainty be prevented, although unquestionably modified. I cannot, therefore, endorse Mr. Jonathan Hutchinson's statement that "I never expect to see secondary symptoms now if I have seen the case before we begin."* Severe papular or pustular eruptions, with or without iritis, or albuminuria, are ordinarily due to severe infection with syphilis, to absence of treatment, and to inadequate treatment, such as grey oil. It is necessary to be more stringent in dealing with such patients than with the general run of cases who have a mild ephemeral roseolar rash, or sore throat and slight glandular enlargements. Patients

* *Second Report of Advisory Board on the Treatment of Venereal Diseases in the Army*, 1905, p. 10.

with severe lesions, if robust, usually stand mercury well, especially by the inunction form. For such cases three courses of forty inunctions ung. hydrarg. B.P. in doses of 1 drachm in the first nine months is, I think, essential, daily warm baths and free dietary being almost as important as the drug treatment.

At Woolwich some 1000 or more venereal cases are annually admitted as in-patients. The local garrison is 5000 strong, and numerous cases also come from the adjoining London garrison, 4000 strong, also colonial foreign invalids, and men on furlough from other stations. Syphilis in all stages comes under close observation, but more especially the initial and secondary lesions. A contrast between the effects of treatment in civil and military communities is unfair to the former. In the Army, excluding foreign invalids, we ordinarily deal with picked healthy adults. The men are well housed, well clothed, and well fed. When sick they are treated in the early and more remediable phases of disease as in-patients in hospital under the best hygienic conditions and with an ample dietary, a most important consideration in dealing with syphilis. The treatment ordered is carried out by specially trained orderlies under the daily supervision of an officer. In civil life, in hospital practice on the other hand, the patient continues at his work, and the above conditions can rarely be fulfilled since there are only some fifty beds in the whole of London (a city of 5,000,000 inhabitants) for the in-patient treatment of venereal diseases. As a result of this defect, venereal disease is sown broadcast amongst the population, and the resulting insanity due to syphilis is dealt with in lunatic asylums maintained at immense cost by the State. Further, the out-patients have not the means to buy good food, and they ordinarily live under very bad hygienic conditions. They take their medicine or not as they please, and whilst frequently forgetting their treatment, too rarely forget the temporary stimulus afforded by alcohol in the local gin-shops, which naturally accentuates their disease and preserves their syphilis. Venereal diseases should be notifiable, and cases treated as in-patients for a period of one to two months in the communicable stages. In better-class private practice the patient commonly essays to conceal the origin of venereal disease from the doctor, and naturally desires to keep the fact of its existence from his friends and relatives. In military practice concealment, when

detected, is an offence with penalties. The medical man in civil practice is consequently forced to accommodate himself to the circumstances of the individual case, and treatment may thus be unfairly crippled, or too frequently has to be made subservient to the convenience and caprice of the individual patient. I fully realise the difficulties of the situation, but do not agree with Colonel Lambkin, R.A.M.C., "that our great hospitals make no attempt at curing"; * that "in ninety-nine cases out of a hundred in England at the present day the treatment is one of symptomatic amelioration, and generally speaking no real attempt is made to deal with the disease." †

The Augean stable has first to be cleansed by a better system and a few legal enactments. Our great hospitals may bring a man to their out-patient clinics, but they cannot make him drink his medicine or admit him for treatment. The reduction of syphilis within the Army in recent years is mainly dependent on treatment in hospital, and on the adoption of a valuable system of "out-patient" control and supervision throughout the whole British Army, with a continuance of treatment for two years and observation for a further year. In July, 1903, I forwarded to the War Office some printed matter published in India in 1901 to show the absolutely fundamental importance of collecting accurate statistics of syphilis, and so ensure the more exact diagnosis of non-infecting chancre (soft chancre) and infecting chancre (syphilis), since adequate treatment necessarily implies the accurate diagnosis and recognition of early syphilis. The statistics of venereal disease in the British Army in the past have been commonly rejected at international congresses, etc., owing to their inaccuracy. I further suggested that a strict record of re-admissions to hospital for relapse of syphilis should be accurately kept, in order to verify the curative value of various forms of treatment, and finally, that as the neglect of adequate treatment of syphilis, especially in the early stages (first six to nine months), was a principal factor in perpetuating the disease, that the purely symptomatic treatment should entirely cease, and that prolonged out-patient treatment and supervision should later supplement hospital treatment in the Army in order to prevent relapse and consequent re-admission to hospital. The above suggestions, fully

* *The Hospital*, June 29th, 1907. Reprinted in the *Journal R.A.M.C.*

† *Ibid.*

set forth in the preface to my recent book,* were given effect to by the War Office, who put forward a temporary scheme in September, 1903, for the more accurate diagnosis of syphilis and soft chancre, and arranged, by Army Order 158 of September, 1903, for the regular out-patient attendance of soldiers. This Army Order, which has had a world-wide effect, was later embodied in the King's Regulations, paragraphs 1080, 1174, and provides that "soldiers temporarily unfit, but for whom treatment in hospital is not essential, will attend at the hospital or inspection-room as directed by the medical officer. They will not be permitted to leave barracks, and will be excluded from the canteen. They will be relieved from all duties or employed on light duties and fatigues according to medical recommendations." The pay warrant also provides that a soldier who is physically inefficient from venereal disease or its effects forfeits service pay, which is restored to him on return to ordinary duty when considered efficient by his commanding officer. In January, 1904, the results of the previous scheme proving favourable, a permanent scheme—"Instructions regarding Procedure in Cases of Syphilis"—was taken into force throughout the Army in England and abroad wherever British troops were stationed. These instructions were later embodied into Appendix VII, Regulations for Army Medical Services. Briefly, these instructions contain the suggestions set forth in July, 1903, and also arrange for a syphilis case-sheet for every man, which is transferred with him. Statistics are rigidly collected and individual initiative stimulated, whilst the results of treatment are tabulated. The reduction of venereal disease in the British Army has thus been enormous, and the good results have reacted also on the civil community, but there is plenty of scope for more thoroughly detecting and treating early venereal disease, both amongst soldiers and civilians.

I have given the above history in some detail, as an inference has been recently made by Colonel Lambkin, R.A.M.C., whereby the brilliant results latterly obtained in the British Army were attributed to the particular method of administering mercury, so strongly advocated by him, of treating soldiers by intra-muscular injections of mercurial preparations, such as grey oil (Lambkin's cream).† Although

* *Syphilis in the Army*, 1907. London: John Bale, Sons & Danielsson.

† *Journal R.A.M.C.*, May, 1908, p. 559; replied to in the July, 1908, number of the same journal.—H. C. F.

the grey oil treatment was introduced about 1891 the marked reduction in the Army has only occurred during the past five years or so in England, and in India since the control of diseased women commenced in the year 1898 onwards. In 1897, amongst the British Army in India, syphilis reached the highest ratio on record, namely, 106 admissions per 1000 men, whereas in 1903 it was only 46 per 1000, and yearly less ever since. In 1896 to 1899 in India I, in common with other officers, used soluble perchloride of mercury injections and mouth treatment for out-patients, whose attendance at that time was not compulsory as it now is, since September, 1903. I found these soluble injections valuable. Brilliant results, therefore, are mainly due to the control of diseased women in India, and to the careful treatment of soldiers in hospital in the initial stages of disease, which lessens the local spread of disease by imperfectly treated soldiers, to continuance of treatment as out-patients, and to the united efforts of Army Medical Officers over a series of years rather than to any special mode of treatment, such as insoluble grey oil, or other mercurial preparation. During the past fifteen years my work has been almost exclusively confined to treating venereal diseases in large military stations at home and abroad. During this period I have extensively tried most of the recognised modes of administration, by the mouth, by inunctions, by injections, and by calomel vapour baths. In early syphilis—that is, during the chancre and early rash stage—and before the disease has become established, I am firmly convinced that both the mouth and inunction methods of administering mercury in suitable and average cases are infinitely preferable as regards curative action on syphilis, to the injection of insoluble salts, such as grey oil. I have given some thousands of these intra-muscular injections and recorded the results in order to study the relative effect both on in-patients and out-patients. During the past year at Woolwich I have conducted a close research on this point. I find that when inunctions of ung. hydrarg. B.P. are judiciously used, the induration of the chancre and of the lymphatic glands is much more rapidly and thoroughly dissipated, and that a gain of several pounds is the rule and not the exception. I have found severe relapses and loss of weight to be much more common after the use of insoluble grey oil, the lymphatic glands are not nearly so beneficially affected, syphilitic nervous lesions

are more common, and soldiers have to be re-admitted to hospital.* In the army, in the case of in-patients who are necessarily in hospital in the chancre and rash stage, we are chiefly concerned in trying to arrive at what best holds the syphilis in check. In the garrison of 5000 men, in the year 1903, at Woolwich, the intra-muscular injections of insoluble grey oil were ordinarily used. There were 477 admissions for syphilis, which included many relapse cases, the average number of men daily sick in hospital with syphilis being 54. In 1904, intra-muscular injection of mercury was used for in-patients, but owing to the inauguration of the rigid out-patient system from January, 1904, already outlined, there were only 331 admissions for syphilis, the average number of daily sick in hospital being 56. In October, 1905, I initiated inunctions of ung. hydrarg. and baths for in-patients, weekly grey oil injections being reserved for out-patients. There were 202 admissions for syphilis in 1905, average daily sick being 30. In 1906 there were 129 admissions for syphilis, and the average number of daily sick was 13, the strength of the garrison being 4500 men. These good results accrued from the number of re-admissions for relapse and the number of daily sick being reduced, owing to more efficacious treatment whilst in hospital in the early phases of the disease. In 1907 there were 87 admissions for syphilis, the same practice continuing. In 1908 the average number of in-patients for syphilis is 9 in a garrison of 4500 men, at the date of writing—August, 1908. Further, in 1905 there were some 150 men attending weekly as "out-patients" for syphilis. The average number of out-patients attending weekly during the present year is 61. This reduction amongst out-patients is also due to more effective in-patient treatment in the early phases of disease by inunctions of mercury, baths, and full dietary. Cases which have not received thorough inunction or mouth treatment whilst in hospital in the early chancre or rash stage very commonly relapse and have to be re-admitted to hospital. Naturally there are a very large number of cases of syphilis which present very slight skin or mouth manifestations at any period of their syphilis, and grey oil injections in such cases have obtained a quite undeserved amount of credit. In severe cases, in obstinate skin or mouth lesions, the curative action of insoluble grey oil is frequently

* Confirmation of these conclusions is to be found in an article by Capt. Dorgan, R.A.M.C., in the *Journal R.A.M.C.* for August, 1908.

not apparent, and in order to dispel the lesions I am commonly obliged to adopt other methods. Amongst the 87 admissions for syphilis in 1907, no less than 22 were cases of relapse occurring in men whilst out-patients under active mercurial treatment by intra-muscular injections of insoluble grey oil.

Lang, of Vienna, "first introduced grey oil in 1886. He objects to intra-muscular injections as these are more liable to be followed by complications."* Lang commonly uses the inunction method. Lafay, of Paris, modified Lang's formula. Dr. Althus, of London, introduced grey oil into England. Colonel Lambkin in the British Army has used it since 1891, at first using Dr. Althus's cream. Lambkin's formula, "especially in its later form, closely resembles the grey oil of Continental writers."† I question the "slow absorption and elimination" of insoluble salts of mercury as set forth by Colonel Lambkin,‡ since both are reported to have been sufficiently uncertain, rapid, and irregular to cause mercurial poisoning in well authenticated cases, and even deaths due to this method are recorded in Surgeon-General Fawcett's article on Egypt.§ Other deaths and cases of poisoning are recorded.‖ The fact of accumulation of insoluble salts of mercury at the site of injection is largely owing to the introduction of insoluble material into muscles primarily intended by Nature for locomotion. The salt, therefore, is not regularly absorbed, and may be suddenly eliminated. Further, there is no premonitory warning or adequate means of control as with other safer methods, when mercurial stasis occurs, and this dangerous condition is naturally apt to occur more frequently with insoluble salts. It is common knowledge that mercury, like arsenic, has a cumulative action in the body, so that it is not so much the intake as the output that we must look to. This may explain the bad results with atoxyl. The consensus of English opinion in civil prac-

* *Third Report of Advisory Board on the Treatment of Venereal Diseases in the Army*, p. 29.

† *First Report of Advisory Board on the Treatment of Venereal Diseases in the Army*, p. 16.

‡ *Journal R.A.M.C.*, May, 1908, p. 558. Replied to in the July, 1908, number of the same journal.

§ *First Report of Advisory Board on the Treatment of Venereal Diseases in the Army*, Appendix A, p. 64.

‖ *First Report of Advisory Board on the Treatment of Venereal Diseases in the Army*, p. 27.

tice is strongly adverse to the use of insoluble salts of mercury for intra-muscular injection. Dr. A. Whitfield, London, "considers the use of insoluble preparations such as grey oil as hardly justifiable in view of the recorded deaths from this method of treatment." * Mr. Charles Gibbs, London Lock Hospital, states that "severe relapses are twice as frequent after injections as after inunctions or pill treatment, and iritis is peculiarly common in the relapse after intra-muscular injection." † Other experts state that "it decimated their clinics." Mr. Arthur Ward, in revising the records of the Lock Hospital, London, says "he was struck by the numbers of patients who only took one injection and never came again." ‡ Mr. Jonathan Hutchinson does not consider "it so good as the administration of grey powder." § Dr. Radcliffe-Crocker remarks: "From a study of the literature of the subject it seems that the dangers from insoluble preparations are considerably greater than those from soluble, and if salivation once sets in you have no controlling power over it at all." ‖

The foregoing independent testimony, contained in the *Second Report of the Advisory Board on the Treatment of Venereal Disease in the Army,* is that of a committee specially appointed to go into such matters, the views being those of leading experts in London.

(*To be continued.*)

SEVENTY-SIXTH ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION, HELD AT SHEFFIELD, JULY, 1908.

REPORT OF THE PROCEEDINGS OF THE DERMATOLOGICAL SECTION.

By GEORGE PERNET, M.D.

The Section of Dermatology of the British Medical Association meeting held this year at Sheffield was very successful from every point of view. The President of the Section was Dr. Graham Little, and the secretaries, Dr. Pernet and Dr. Archibald Young. The bulk

* *Second Report of Advisory Board on the Treatment of Venereal Diseases in the Army.*

† *Ibid.*

‡ *Ibid.*

§ *Ibid.*

‖ *Ibid.*

of the work of organising the meetings, museum, etc., fell on the shoulders of the local secretary, Dr. Young, and the local organising committee.

The first meeting was held on Wednesday, July 29th, the proceedings opening with an address by the President, in which he specially welcomed the foreign guests, Professor Neisser of Breslau, Drs. Sabouraud and Noiré of Paris, Professor Gilchrist of Baltimore, and Dr. Garceau of San Francisco, who had responded to his invitation to attend the meeting. He alluded also to the great loss they had sustained in the persons of the late Professor Lassar of Berlin, and the late Sir J. McCall Anderson of Glasgow, men who had done so much to advance dermatology.

Dr. Sabouraud read a paper on "The Dermato-mycoses Common to Man and Animals," limiting his remarks to the various kinds of ringworms which he had particularly studied. He had brought over with him a fine collection of cultures, some of them showing the results of his more recent investigations, which are known to dermatologists. But the advantage of seeing the actual cultures was of the greatest value and interest to those attending the Section. Dr. Leslie Roberts followed and reviewed the subject exhaustively, touching not only on the ringworms, but also on a number of morbid skin-affections common to man and animals, and conveyed from one to the other, insisting mainly on those forms transmitted from the domesticated animals to man. His paper will make interesting reading when it is published in full in this journal.

The paper on "The Treatment of Skin-diseases by Ionisation" by Dr. Lewis Jones (a guest of the Section) was illustrated by a beautiful demonstration of copper and iodine ions.

Dr. Noiré gave an extremely lucid account of his work in connection with "The Treatment of Hypertrichosis by means of the X-rays," at which he had been working for some time, with satisfactory results up to the present.

Dr. Sequeira followed with a paper embodying the results of his investigation "On Calmette's Ophthalmo-tuberculin Reaction, with special reference to the Diagnosis of Cutaneous Tuberculosis."

On the second day, Thursday, Professor Neisser delivered an address on "Modern Syphilis," in which the results of his work in Java were crystallised. The importance of the subject attracted a

good audience, but not nearly so large as the subject deserved, for it was one that concerned all medical men, whatever their line of work. The paper was illustrated by lantern slides. Sir Malcolm Morris, in well chosen words, congratulated Professor Neisser on the way he had devoted his private fortune to the furtherance of knowledge, and then on his experimental work in connection with the problems of syphilis. In the interesting and animated discussion which followed the following gentlemen took part: Dr. Gardner, Professors Gilchrist (Baltimore) and Grünbaum (Liverpool), Dr. Douglas Heath, Dr. Louisa Appel, Dr. J. J. Pringle, Dr. J. Galloway and Dr. Pernet.

Professor Gilchrist's lantern demonstration of the histological appearances found in experimental urticaria was extremely instructive and showed painstaking research.

Papers by Dr. Bunch on "The Bullous Eruptions in Children"; Dr. Lancashire on "The Treatment of Lupus Vulgaris," a comparative review of the various methods employed hitherto; and by Dr. Garceau (San Francisco), on a case of Mycosis fungoides observed by him in California, were then read and discussed.

The meeting on the last day (Friday) opened with a clear review of his work in connection with vaccine-therapy and its relation to diseases of the skin by Sir Almroth Wright, and it proved of great interest.

Various papers by Dr. F. Gardiner on "Trade Dermatitis," Dr. Eddowes on "Eczematous and Bullous Eruptions," and by Dr. Tomkinson on "Lupus Vulgaris treated by Sun-rays" brought the proceedings of the Dermatological Section to a successful close.

Some clinical cases were shown, but they were not of such interest as one might have expected in so populous a place as Sheffield. This may to some extent be explained by the statement one heard that the people of Sheffield preferred to go to a doctor privately rather than to a hospital. *Si é vero,* it says much for the independence of the denizens of the city of steel.

In the Museum, the exhibit of numerous drawings and wax models, together with specimens and cultures, was certainly far above the average.

Altogether in every way the Section was very successful, and in quality one of the best held in recent years.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

A Meeting of this Section was held at 20, Hanover Square, on Thursday, October 20th, Dr. H. Radcliffe-Crocker, President, in the chair.

The following cases were exhibited:

Dr. H. G. Adamson showed (1) photographs of a case of *favus of the glabrous skin*, and of cultures from the same of the type known as *Achorion Quinckeanum* of Bodin. The patient was a boy, aged 10 years, who presented, on the side of the neck, an oval, sharply circumscribed, erythematous and slightly crusted patch measuring $\frac{3}{4}$ in. by $\frac{1}{2}$ in. The patch might well have been diagnosed as a ringworm, but for the fact that there were on it three small well-formed sulphur-yellow cups typical of favus. The case was unusual in that the boy was of English parents, most cases in London (in the exhibitor's experience at any rate) being children of Polish or Russian parents. One of the cups was removed, and portions of it were sown on tubes of maltose agar (Sabouraud's proof medium). In a very short space of time there developed from every point of inoculation (ten in all) pure and luxuriant downy white cultures, very unlike the brownish vermiform slow-growing cultures of ordinary favus (*Achorion Schönleinii*). The exhibitor was unfamiliar with these growths, but on seeing the cultures which were exhibited by Dr. Sabouraud at the Sheffield Meeting of the British Medical Association he at once recognised them as identical with the growths labelled *Achorion Quinckeanum*—Favus souris. The case thus becomes interesting as being the third recorded example of this type of favus in the human being. The other two cases were reported by Bodin, one in a young girl who presented an erythematous patch with cups upon the cheek, the other in a young woman presenting a circinate erythemato-squamous lesion without cups, so that it resembled a trichophytic lesion, although it yielded the favus cultures. This same culture has been obtained by Bodin and by Sabouraud from favus of the mouse. A peculiarity which the *Achorion Quinckeanum* shares with another rare species of favus, the

Achorion gypseum of Bodin, is that their fruit organs—chlamydospores, spindles, and spore-bearing hyphæ—resemble those of the trichophytons and microsporons, and not those of ordinary favus (*Achorion Schönleinii*), although clinically they are true favus.

Sabouraud, in his paper referred to and published in the *British Medical Journal*, October 10th, 1908 ("The Dermatomycoses Common to Man and Animals"), recognises only these three known species of favus:

(i) The common favus due to the *Achorion Schönleinii*, forming 99 per cent. of the cases of ordinary favus, usually contracted by child from child, but sometimes from the mouse or the cat.

(ii) *Achorion Quinckeanum* (Bodin) with white culture (that here exhibited), found on the mouse, and on one occasion in a lesion of the human skin.*

(iii) *Achorion gypseum* (Bodin), also rare, with pale brown, shaggy culture: found once in a human favoid lesion by Bodin, and once in a young horse by Suis, of Toulouse.

(2) A well-marked example of *arsenical pigmentation* with *hyperkeratosis of the palms and soles.* The patient, F. B—, was a house-painter, aged 28 years. The pigmented condition of the skin had been present for some four or five years. The skin of the whole of the trunk and for some distance along the arms and thighs was deeply pigmented and characteristically spotted by closely set, rounded, split-pea-sized pale areas. The areolæ of the nipples were almost black. The face, the forearms, and the legs below the knees were free. The palms and soles showed considerable thickening of the epidermis in the form of crowded, flattened warty growths, and on the dorsal surfaces of the fingers and toes there were numerous flat, isolated warty growths. The patient had all his life suffered from fits, and since the age of fifteen years he had regularly taken medicine on this account, so that, in the absence of more direct evidence of arsenic having been administered, it seemed probable that arsenic had been given as a guard to bromides.

The PRESIDENT said the hair-follicles were not yet affected, but they would get filled up, and the white spots would become obliterated if the condition persisted.

* Sabouraud omits Bodin's second case, possibly because the human lesions were not typically those of favus.

Dr. WHITFIELD said some of the pigment in such cases was actually in the epidermis, and could be scraped off. Those who published particulars of the Manchester epidemic noticed the same thing.

Dr. ADAMSON, in reply, said there was a good deal of itching in the case, and the patient came on that account. He thought X-ray treatment would be useful to allay the itching.

(3) A case of *Erythema serpens* of Morrant Baker, or *erysipeloid* of Rosenbach. The patient was a woman, aged 28 years. About two weeks ago she had slightly wounded the left forefinger and the right thumb while cutting up raw meat. Soon afterwards the finger became stiff, red and painful. When first seen nine days ago there was, upon the dorsal surface of the left forefinger, occupying the middle and proximal phalanges, a circumscribed, red, swollen, tender area, with a well-defined, slightly raised, wavy margin. On the right thumb there was a similar oval area, measuring 1 in. by 1½ in. Both lesions itched very much and were painful and tender. A few days later the redness had spread on to the back of the left hand, and the patch on the right thumb had enlarged. The serpiginous margin was well marked in both lesions. The original wounds were represented only by a little thinning of the epidermis with a few loose scales. The patient was considerably worried about the condition of the fingers and felt out of sorts, but there was no rise of temperature, and no lymphangitis along the arm nor any enlargement of glands.

The case was evidently the affection described by Morrant Baker in 1873 (*St. Bartholomew's Hospital Reports*) as "Erythema serpens," and since by Rosenbach in Germany as "erysipeloid." Both observers had noted the frequency of the eruption as a sequence to a minute injury while handling uncooked meat, and the condition was not uncommonly seen at St. Bartholomew's Hospital in butchers from the Central Meat Market close by. Gilchrist, in America, had described a like affection in persons who handled crabs, and some cases had been recorded in America in laboratory workers. Rosenbach had found an organism which he believed to be a cladothrix, and had reproduced the disease by experimental inoculation from cultures. Gilchrist found no organism, and the present case and one other had been examined for the exhibitor by Mr. W. G. Ball, with negative results. Gilchrist suggested that the disease might be caused by a special ferment.

Dr. Whitfield remarked that the only case of the kind which he had seen was in a friend who derived it from a cray-fish. He had had a very bad hand for some time.

The President said such cases were not now seen as often as previously.

Mr. T. J. P. Hartigan showed (1) (with Mr. Stuart-Low) a case of *rhinoscleroma*. This case had been recently shown at the Laryngological Section by Mr. Stuart-Low, whose description will be found reported in the *Proceedings* of the Society, which the exhibitor unfortunately had not yet read. The patient, a female, aged 28 years, born in the south of Russia, had not been out of England for the past thirteen years. There was no evidence of syphilis. The disease commenced eight months ago at the outer margin of the left anterior nares, which it now completely envelops, together with the septum and adjacent half of the right anterior nares; downwards it has extended slightly into the upper lip, and upwards the anterior two thirds of the left nostril is affected. The nose is broadened and the left ala considerably thickened.

The palate and naso-pharynx are not affected. The parts involved are hard to the touch, but the induration is not as marked as one might expect, and is painful, especially so on pressure. The efflorescence is of a pinkish colour, the epidermis over it intact, except at the front and back of the left nostril, where it is eroded, covered with nodules, and secreting a viscid fluid, but whether this is traumatic —the left nostril having been scraped out—or not the exhibitor is unable to say. He had not seen a section of the case, but Mr. Stuart-Low had informed him that Dr. Wingrave had prepared some and they were quite satisfied as to the histological findings.

Mr. Hartigan himself had no difficulty in finding the bacillus of von Frisch in the secretion and from a puncture, and in this respect the analogy between rhinoscleroma and cutaneous leprosy was very striking. To the remark that the bacilli were not encapsuled he observed that staining by Gram's method was not calculated to show up the capsule, but on careful examination traces of it were evident.

Taking the diagnosis as correct the case was especially interesting as showing that the bacillus was, as von Frisch originally described it, only about half as long again as it is broad, and not four or five times as usually stated, and further, that it was an iodine-fixed or Gram-staining bacillus. The rarity of the affection in this country

may be inferred from the fact of its being the first case to be exhibited at this Section, and he need not add that to dermatologists it is one of great interest.

His main purpose, however, in bringing the case before members was to discuss the question of treatment, and seeing the facility with which the organism can be cultivated and isolated, he had concluded that the proper method of treatment in this case was by therapeutic inoculation, controlled from time to time by determining the patient's opsonic index. Judging by analogy with allied diseases this ought to succeed, and, indeed, a case has already been treated with considerable success by Ymola with rhinoscleroma toxin. The course he had planned commended itself to Sir Almroth Wright and Captain Douglas, who had kindly consented to carry out the necessary investigations. He ought to add that neither of them had seen the case up to the present.

The PRESIDENT said it was a very interesting and important case, but did not quite accord with the usual clinical descriptions of rhinoscleroma. Still, having got the bacillus of the disease one could not get behind that. He suggested that a small committee should be formed to report on the case, consisting of Mr. Hartigan, Dr. Whitfield, Dr. Adamson and Dr. Bunch. He did not think indigenous rhinoscleroma had previously been reported in this country, and therefore any report on the matter would come with much greater force if supported by the findings of a committee.

Mr. HARTIGAN agreed to the suggested committee, but reminded the President that Mr. William Anderson brought forward a case at the Dermatological Society of London, the patient being a boy, aged 4 years, who was born in England.

(2) *Trophic ulcer of the right foot, healed by cataphoresis.* The patient, a female, aged 28 years, was run over when eighteen months old, the wheel of the vehicle passing over her right leg, the horse treading on her sacrum. Both legs were paralysed, the left subsequently recovering. In the opinion of Dr. Purves Stewart, who was kind enough to see this case with him, in addition to the injury below the knee the patient had sustained a unilateral injury to the cauda equina. She had a trophic ulcer occupying the flexure of the right big toe, extending down to the bone, which had existed for three years. This was treated with copper ions on July 10th, the patient being allowed to leave the hospital; within a month it had healed up as completely as one can expect such tissue to heal. On August 21st a second application was made as a matter of precaution, and he

submitted the result was such as could not be obtained in out-patient practice by any other method.

(3) A case of ? *Erythema exudativum multiforme.* The patient is a female, aged 11 years, the fourth of a family of six children, the others never having had an illness. Her parents are alive, the mother having had rheumatic fever. At the age of three, small ulcers broke out on the legs and buttocks, the scars of which are still evident, for which she attended at Westminster Hospital for six weeks and was cured. The following year a condition of things occurred similar in appearance to what she now presents, except that the spots were smaller and the face was not affected, and culminated in that year in an operation at Guy's Hospital for a lesion of the lower jaw, which was followed by cicatricial contraction, so that now she can hardly open her mouth, which is horribly fœtid. Mr. Percy Edgelow, who was kind enough to examine her teeth recently, reported that as far as he could see they were very loose and the alveolar process behind the incisor teeth was necrosed. This has since come away. She has never lost the spots, and during the past eight months has got worse, the efflorescence coming out in crops and extending from the extremities to the face. The outbreaks, which are usually ushered in by articular pains and œdematous swellings, having a similar distribution to the spots, viz. the extremities and face, are at other times associated with evidences of gastro-intestinal irritation, such as abdominal pain and melæna; occasionally there is epistaxis, and subconjunctival hæmorrhages are frequent. There is no albuminuria. Beyond ascertaining the "coagulation-time," which is markedly delayed, the blood has not been examined. The elementary cutaneous lesion is a red papule, which, as it extends peripherally with an elevated margin, clears up in the centre, leaving marked pigmentation and forming circular and polycyclical figures. The colour cannot be expressed from them yet, and this is important as shown by the sections from the spreading edge, where neither blood-cells nor pigment were found to exist. Clinically it would be described as a purpura, but histologically all the appearances are those of an Erythema exudativum multiforme, although the chronicity would exclude it from being so classified. He should be glad to have the opinion of members on:

(i) As to how they would classify this disease.

(ii) The causation of the patient's condition, he himself believing it to be of septic origin in the mouth.

(iii) Seeing the debilitated condition of the child whether they would concur in advising surgical intervention.

The President said he had no doubt that the case was toxæmic, and that it was one for the surgeon. Usually the difficulty was to know where the toxin came from, but the hæmorrhage from the bowel in this case gave a clear indication.

Dr. Pringle pointed out that a similar condition was figured in the *St. Louis Atlas* as Erythema purpuricum.

Dr. Graham Little showed (1) a case of *tertiary syphilis* of unusually extensive distribution in a man, aged 38 years, whose history presented points of interest. The patient denied all knowledge of a primary sore or secondary eruption, but on the glans penis there were two small scars the size of a split-pea which might be the remains of a Herpes preputialis or of multiple chancres. Three years ago the first symptoms of eruption had made its appearance, and was ascribed by the patient to his having pricked himself with a pear-stock. The first lesion had been apparently a nodule on the left side of the chest, and from this beginning a large sheet of infiltration had slowly spread. At the present time the whole of the left side of the chest, and the whole back from the neck to the lower level of the thorax, and the upper arms, back and front, to the level of the insertion of the deltoid, were occupied by a dense infiltration studded with numerous hob-nail elevations and white round scars the site of similar previous lesions; there were also numerous shallow ulcerations interspersed in the infiltrated tissue, some of them scabbed over, others covered with a thin slough. The face, tongue and throat were completely free from disease, but there was a history of frequent ulceration of the throat five years previously.

The patient was a robust, extremely healthy-looking man, who had no symptoms in connection with his illness except an unusual itching in the site of his disease, which was severe enough to keep him awake. His wife had had no miscarriages, but had ceased to bear children after the birth of his first child, seven years ago, and a year after his marriage.

In addition to the distribution above described there were two white scars, one on each thigh, the size of a five-shilling piece, the

sites of lesions which had come soon after the first invasion and had healed. There was a similar scar on the pubic area of the abdomen. The patient had had no treatment of any kind for the disease.

A section of one of the hob-nail elevations had been procured, and showed a dense infiltration of the deeper parts of the corium with cells consisting chiefly of plasma-cells. The connective tissue and elastic fibres were greatly disintegrated and lacking in the greater part of the section.

(2) *A case for diagnosis.* The patient was a somewhat delicate-looking woman, aged 40 years. When twelve years old she had contracted variola, and a year after she had begun to have the present eruption. At the age of fifteen she had been an in-patient for six weeks in the London Hospital for this disease, but had not materially benefited by the treatment. The disease had persisted ever since, and according to the patient's account individual lesions had been permanent during at least twenty years. They were itchy, and she got, from time to time, fresh lesions which appeared to be quite typical urticarial wheals. Factitious urticaria, to a degree comparable with "dermographism," was present. The permanent lesion appeared to be an erythematous papule; all the redness faded on pressure, but a slight but definite pigmentation of a pale buff colour was left, even when considerable pressure was exerted with a glass slide. The papule was usually quite small, none of the lesions being larger than $\frac{1}{8}$ in. across, and many of them were smaller than that. The papules were very closely juxtaposed on the breasts, the forearms, the back of the shoulders, and the abdomen. Upon the forearms and backs of the hands there were flat, more pigmented, macular lesions; on the soles and at the edge of the dorsal and plantar surfaces of the foot there was a blotchy, persistent erythematous eruption. All the lesions became reddened and slightly turgid on friction, and considerable irritation was complained of. The diagnosis very tentatively suggested by the exhibitor was that of Urticaria pigmentosa, and he purposed obtaining a biopsy and investigating this supposition.

Dr. Crocker did not think the case clinically justified the diagnosis of Urticaria pigmentosa. All that could be definitely stated about it was that it was an urticarial condition leaving persistent lesions—if that part of the history could be relied upon.

Dr. Whitfield did not agree either with the diagnosis of Urticaria pigmen-

tosa. The condition seemed to him quite unique and unprecedented. Some of the lesions had the appearance of telangiectases.

Dr. ADAMSON was inclined to support the diagnosis of Urticaria pigmentosa offered by Dr. Little.

(3) A case of systematised *Nævus verrucosus* in a boy, which will be more fully reported later.

Dr. GRAHAM LITTLE showed, for Mr. ARTHUR SHILLITOE, *a case for diagnosis*. The patient was under the care of Mr. Ernest Lane in the Lock Hospital. The history was that two years ago, after sexual intercourse, the patient noted a small sore on the penis, from which the present growth had slowly spread. There was no history of syphilis, and this infection could be excluded. When shown, the penis and the front surface of the scrotum were buried in piled-up masses of succulent, warty, very fœtid excrescences, the whole producing a tumour the size of a large fist. There appeared to be no actual ulceration of the tissues of the penis or scrotum, and no necrosis of the new growth; urination was somewhat impeded.

The general opinion was that chronic pus infection was responsible for the greater part of the swelling, but it was recommended that a biopsy should be made of the warty growth. This was effected at St. Mary's Hospital, and proved the growth to be a simple papilloma, with no appearances of malignancy.

Sir MALCOLM MORRIS and Dr. DORE showed a case for diagnosis. The patient was a dark-complexioned man, aged 38 years, an Englishman by birth, who had lived for twenty years in South Africa, where he had been a bank manager.

He suffered from a chronic ulcer in the right lower abdominal region, which began eight years ago, and had been in an ulcerating condition for four years. The ulcer was roughly circular in shape, and measured 2½ inches in its longest transverse diameter and 2 inches vertically. When first seen it presented a purulent granulating base, covered by loose heaped-up crusts and a clearly defined festooned indented border. There was evidence of scar-formation corresponding to one of the indentations, but the ulcer was comparatively superficial, and there was very little surrounding infiltration. At the time the case was shown the ulcer had healed as the result of X-ray treatment.

In addition to the ulcer there were several slightly scaly brown

patches of varying size and shape in the right inguinal region, on the back, above the right elbow, on the left outer malleolus, and in the neighbourhood of the right great trochanter, which apparently represented an early stage of the disease. The last one in particular showed a raised spreading edge similar to that of the lesion on the abdomen, but none of them had ulcerated. The origin of the ulcer by gradual evolution from one of these patches was also borne out by the history given by the patient. He first noticed slightly irritable brown patches on the arms and other parts of the body about twelve years ago when he was in South Africa, and these gradually increased in size; some had been cured by chrysarobin ointment, but none had disappeared simultaneously.

One of them ulcerated after he had applied an ointment, the result being the ulcer of which he now complains. He also attributed the continuance of the ulceration to chafing by his clothes.

He could not suggest any cause for the origin of the disease. As regards his family history, his father and mother were healthy during their lifetime, a brother died of phthisis, four brothers and a sister are living and healthy. The sister has had a patch on her knee and elbow for several years, which he thinks is of a similar character to his own complaint. During the twenty years he was in South Africa he had travelled about the country and had been exposed to tropical heat, but with the exception of dyspepsia he had remained in good health. The only serious illness he had had was rheumatic fever in early boyhood. He had never had syphilis, but he remembered having slept with a companion who had circular patches on his wrists and palms at about the time he first noticed the spots on his own body. He had seen several "Veldt sores," but none of them resembled his own.

As the ulcer did not yield to ordinary applications, including picric acid, X-ray treatment was suggested by Sir Malcolm Morris and was begun on September 24th. Short daily exposures were given; healing began after the fourth application and was complete in three weeks, after he had had eight exposures. Before the X-rays were applied, scrapings were taken from the edge and films and cultures were made from the ulcer. No mycelium or yeast bodies were found; the films showed a large number of cocci, some of very large size and some in the form of diplococci.

Cultures on agar slopes gave rise to a freely growing pigmented Gram-negative organism, which on further investigation, kindly undertaken by Dr. MacCormac, proved to be *Bacillus prodigiosus*. Some of the tubes subsequently showed *Staphylococci aureus* and *albus*, and it was suggested that as *Bacillus prodigiosus* is used to raise the virulence of typhoid bacilli, it might have had a similar effect in lowering the vitality of the tissues and increasing the pathogenic action of the staphylococci in the present instance. There was, however, no reason to suppose that the condition was a staphylococcal infection from the start. No diagnosis was offered, the possibility of the disease being an unusual form of Mycosis fungoides or of a "Veldt sore" being rejected.

The PRESIDENT said he felt rather inclined to regard it as psoriasis.

Dr. MACLEOD suggested that possibly they might be Veldt sores. He had seen two cases of that condition, in one of which the lesions had healed when the patient reached this country.

Major H. C. FRENCH said he had seen several examples of Veldt sores—scabbing conditions with superficial ulceration. The present condition was quite consistent with that. It might take on many forms. He had seen a similar condition in Queensland, but as a rule they did not last very long.

Dr. DORE, in reply, said he thought Veldt sores were more pustular than these lesions. The present condition had never been vesicular, but it was purulent when it was ulcerating.

Dr. PERNET showed a case of *Granuloma annulare*. The patient, was a girl, aged 10 years, in whom, twelve months ago, a small spot had started on the distal end of the fifth metacarpal joint. It gradually increased in size, and when he first saw her there was a distinct raised border, and the lesion was made up of two half circles, more or less irregular. Six months ago a splinter had gone into the right knuckle, and at that spot there was now a lesion of a similar nature. When he first saw the patient there was some matter there, probably a secondary infection. After a week he ordered a placebo ointment. The lesion had now flattened considerably. It would be seen from the photograph taken before anything was applied that the borders were very prominent. There was no history of previous illness, except that some years ago she was troubled with enlarged glands in the neck.

Dr. WHITFIELD suggested that the lesion noted as having resulted from a splinter still contained a foreign body, and the swelling was due to that.

Dr. GRAHAM LITTLE said some such cases seemed to have followed injury, but

the lesion following a splinter seemed to be too red for Granuloma annulare, and he agreed with Dr. Whitfield's suggestion.

Dr. PERNET, on the suggestion of the President, promised to bring the case again on a future occasion.

Dr. SEQUEIRA showed a case of *multiple idiopathic pigment-sarcoma* (Kaposi). The patient, a tall, stout man, aged 84 years, but who looked much younger, was born of German parents in Cardiff. For many years he has been resident in London, and until recently followed the calling of a licensed victualler. He has had numerous attacks of gout, but since infancy has had no other illness until four years ago. At that time the right foot and leg began to swell and small tumours developed upon them. These have steadily increased in number, and more recently the left leg and foot have been similarly affected, but to a less degree. The patient has been under the care of Dr. Sargent, of Shadwell.

Present condition.—The right foot and leg are much swollen, as also are the knee and lower part of the thigh. The skin pits slightly on pressure. It has a rather dark red colour. About the ankle there are numerous purplish-red tumours varying in size from a small pea to a small nut in size. The colour of the tumours is evidently due to blood-pigment. On the sole of the foot are several similar nodules, rather less than a pea in size. Some of these have ulcerated recently from the pressure upon them. The tumours, except upon the sole of the foot, are not painful, but slightly tender on pressure. From the ankle to near the knee the small tumours are sparsely scattered, but at the knee, and in particular upon its outer aspect, they are very numerous and closely placed. Here the swellings are all of larger size and some attain the dimensions of a small cherry. They have all the same dusky, hæmorrhagic appearance.

The left leg and foot are swollen, but to a less degree than the right. The tumours on this side are also smaller, and rarely exceed a pea in size. They are few in number and sparsely scattered. On the dorsum of each hand there is a flat pigmented patch, but these spots do not show the purplish discoloration seen in other parts. The trunk and the rest of the integument of the extremities are unaffected.

There is evidence of chronic interstitial nephritis. There are also

symptoms of prostatic enlargement. The heart's apex is diffuse and displaced down and out. There is no sign of valvular disease. The arteries are thickened and tortuous, but not more so than is accounted for by the advanced age of the patient. Indeed, apart from the condition of the skin and the gout he appears to be a remarkably well-preserved old man.

No microscopical examination has yet been made of the tumours.

The exact relationship of this rare disease to sarcoma has been doubted. Many of the cases show little or no evidence of malignancy. A patient under his care in 1900 gradually got better, and when last heard of was almost well. The microscopical examination in that case, made by Dr. Bulloch, is reported fully in the *British Journal of Dermatology*, No. 152, vol. xiii. Bulloch looked upon the condition as inflammatory. This is confirmed by MacLeod's observations on the case of Weber and Daser (*British Journal of Dermatology*, No. 199, vol. xvii). He described the condition as a growth of organising connective-tissue cells associated with marked vascular dilatation and œdema and deposit of blood-pigment. The relationship to gout has been pointed out by Hutchinson. Gout was present in both his cases and in others described by Hutchinson (*Archives of Surgery*, vol. v, p. 237, and vol. vi, p. 132). Plate 61 in Mr. Hutchinson's smaller atlas is an illustration. Many of the continental cases have been free from gout, and so also was Weber and Daser's patient.

The PRESIDENT remembered that Mr. Hutchinson had pictured the condition in the first volume of his *Illustrations of Surgery*, but it was not such a marked case as the present, which was very extensive.

CURRENT LITERATURE.

TINEA ALBIGENA AND THE CULTIVATION OF ITS FUNGUS.

NIEUWENHUIS. (*Arch. f. Derm. u. Syph.*, vol. lxxxix, No. 1, 1908.)

TINEA albigena occurs frequently among the population of Java. Borneo and Lombok, and among the soldiers of this district. It occurs also in Sumatra and New Guinea, so that it may be said to affect the population of the whole Malay Archipelago, including Europeans resident there. But the greater cleanliness of Europeans, the thinner epidermis of their hands and feet, and their use of boots prevent such an extension of the disease among them as among the natives.

The disease has not only a scientific, but also an economic interest, involving,

as it does, large communities. The most important clinical symptoms which give to the disease its peculiar and important position are the tenderness of the palms and soles resulting from the destruction of their horny surfaces, which make work and progression difficult. The discolouration of the affected part is also very unpleasant; the disease also tends in the absence of treatment to become chronic, and render the disabilities of the patients very trying. At first there appears a nodule with great itching, which is transformed into a bleb 3–4 mm. in diameter, and this dries up in time. Surrounding it is a slight reddening of the surface, but no more definite signs of inflammation. Other blebs and bullæ appear, and on the sole these blebs increase in size, with a considerable amount of itching and consequent scratching.

The exposed red shining surface shows a tendency to dry up and become horny in places; in other parts there is only a thin layer of epithelium. The disease has slight tendency only to healing, and the superficial dermatitis may begin as a chronic affection. The disappearance of pigment shows that the deeper layers also become involved later; other areas than the palms and soles seldom become affected, but the nails are sometimes involved. The distribution is usually symmetrical.

The cause of the disease is a trichophyton, and the arguments in favour of such an origin are as follows: (1) The soles and palms are innervated by nerve terminations and not by nerves as such (nerve trunks), and therefore an internal or constitutional cause is improbable. (2) The distribution of the disease is not along the track of nerves or blood-vessels. (3) The disease is too widely distributed to make a constitutional or trophic cause likely. The causation must therefore be an external one, and the writer was able to discover the fungus in the nail of an affected patient, and inoculate it on healthy nails and from them obtain the fungus again. Microscopical examination showed quantities of mycelium in the diseased parts which corresponded to a trichophyton, and this could be cultivated.

J. L. B.

SKIN CHANGES IN PSEUDO-LEUKÆMIA AND LEUCO-SARCOMATOSIS. C. Kreibich. (*Arch. f. Syph. u. Dermatol.*, vol. lxxxix, No. 1, p. 43.)

The paper contains the description of a case of leukæmic tumours of the face. But, inasmuch as the lymphocytes were increased by 69 per cent., whereas the white blood-corpuscles were not increased, it was a case of pseudo-leukæmia. A second case was one of lympho-sarcomatosis. The primary tumour was situated on the side wall of the pharynx and invaded the surroundings; the lymphatic glands and other organs were also involved, but without the generalised spread of leukæmia. The stomach and intestine mucous membranes were superficially infiltrated, with thickening and contraction of the walls without stricture formation. Spleen and liver were not involved; the bone-marrow was only affected in patches. The tumour-cells were larger than lymphocytes, the nucleus less darkly stained; it showed definite structure and was larger than those of the small leucocytes. There was no spontaneous retrogressive appearances. An increase of lymphocytes appears from the investigations to occur more frequently in lympho-sarcomatosis. A third case was characterised by the

appearance two years previously of an extensive itching affection of the whole body, followed in six months by the appearance of lymph-gland tumours on the neck and in the axillæ. Definite signs of tuberculosis were absent, and there was no reaction to tuberculin. Changes were found in the lymphatic gland tumours similar to those described by C. Sternberg in a peculiar tuberculosis, and in the blood a neutrophile leucocytosis. On the skin were changes corresponding to a recurring papular urticaria, but no persistent elements of urticarial or pseudo-leukæmic character.

J. L. B.

THE QUESTION OF THE TREATMENT OF SYPHILIS WITH ATOXYL. Welander. (*Arch. f. Derm. u. Syph.*, vol. lxxxix, No. 1, 1908, p. 31.)

In consequence of the warm recommendation of atoxyl by Hallopeau and Uhlenhuth, E. Hoffmann and Roscher, as a powerful antiluetic agent, Welander commenced in July the treatment of numerous cases at the Hospital St. Göran. On a large number of cases he made injections every second day, but came to the conclusion that, although atoxyl had a definite effect therapeutically on syphilitic patients, the old drugs mercury and iodine could bring about a quicker and safer result.

J. L. B.

ERYTHRODERMIA DESQUAMATIVA: A PECULIAR UNIVERSAL DERMATOSIS OF BREAST-FED CHILDREN. Carl Leiner. (*Arch. f. Derm. u. Syph.*, vol. lxxxix, Nos. 1 and 2, January and February, 1908.)

Pathological changes in the infant's skin are specially prone to occur, both on account of the delicacy of structure of the epithelium and the numerous irritations and stimuli which are brought to bear upon it from the day even of its birth until the time when it develops more considerable powers of resistance. During the past five years Leiner has seen forty-three cases of a disease in these children, which causes scaliness of the scalp, the scales being greyish-white with a glistening fatty appearance, easily detached and most marked on the frontal and parietal regions. The lesions are accompanied by an intense redness and shininess of the skin, the general appearance corresponding to Eczema seborrhoicum. The lesions extend and the face becomes markedly affected, especially the eyebrows, but the whole of the forehead is seldom involved. The remaining skin of the face is usually of a diffuse red, covered with larger or smaller lamellæ. The whole of the trunk is pinkish, the ears, neck, and shoulders are of a reddish shiny appearance, scaliness is more or less present, and there is but slight infiltration of the skin and little moisture of the lesions. No distinction appears in the extremities as to the involvement of the extensor or flexor surfaces. About 33 per cent of the cases die, and in spite of continued breast-feeding disturbances of the alimentary canal increase, the infant's weight diminishes, and profuse diarrhœa persists. Leiter lost fifteen cases out of forty-five. He gives the history of several cases. Examination of portions of excised skin showed a chronic inflammatory process, with dilatation of the papillary vessels and a certain amount of fluid exudation, resulting in œdema of the epidermis and moistening

of the papillary bodies, rather than any accumulation of fluid either in the epidermis or the sub-epidermoid layers. Parakeratosis results as a rule. In the papillary bodies and the skin glands a further stage of inflammation is shown by a certain amount of cell proliferation and migration of cells into the epidermis and a heaping up of cells between the layers of the horny skin. There is thus an exudatory inflammatory process associated with dilatation of the vessels, œdema of the cutis and epidermis, and parakeratosis.

Erythrodermia desquamativa is said by this writer to constitute an idiopathic erythrodermia, characterised at the beginning by the fatty constitution of the scales, by the absence of an atrophic stage, and its occurrence in children at the breast. These are the children which are almost exclusively attacked, and they are in a certain percentage of cases unable to withstand the disease, and succumb.

J. L. B.

ACUTE YELLOW ATROPHY OF THE LIVER DURING THE COURSE OF SECONDARY SYPHILIS. Veszprémi and Kanitz. (*Arch. f. Derm. u. Syph.*, vol. lxxxviii. p. 35.)

The patient was a young man, aged 21 years, who acquired syphilis in May, 1906. On June 9th he was taken into hospital with a chancre and marked phimosis. In October rapidly ulcerating efflorescences appeared on the body, and he was taken again into hospital on November 1st, 1906. Slight icterus appeared on November 11th. Tenderness made its appearance over the liver, the patient became very somnolent, coma finally set in, and he died on November 18th. Post-mortem, the liver showed signs of acute yellow atrophy, and, as previously stated, the liver changes seem to have taken only twelve days to develop. Icterus syphiliticus runs as a rule a favourable course, but the malignant form leading to death shows post mortem either acute yellow or red atrophy of the liver. Sections of the liver stained by Levaditi's method showed no spirochæte. Numerous spirochæte were, however, present in the skin-lesions.

The liver atrophy is ascribed to some toxic substance, and the authors argue that such a toxic substance is produced by the *Spirochæte pallida*, and because such organisms were present in large numbers in this case they assert that these produced toxines in considerably greater quantity than usual. These toxines, when absorbed, can like other poisonous substances, produce a degeneration of the parenchyma of different organs, and when produced in greater quantities can lead to necrosis and disappearance of the parenchymatous cells and thus bring about the characteristic appearances of acute yellow atrophy of the liver. But this is, of course, mere assumption until it has been proved that the *Spirochæte pallida* during its growth produces a toxine.

J. L. B.

ON THE USE OF THE SABOURAUD PASTILLE FOR THE MEASUREMENT OF X-RAYS. Agnes F. Savill. (*Archives of the Röntgen Ray*, May, 1908, p. 340.)

The writer gives the results of fourteen months' work, during which time strict records of the electrical readings of the apparatus were kept and special attention was directed to the behaviour of the Sabouraud pastille under varying conditions. With regard to the reliability of the pastille in a damp climate and

the effect of the weather on the time of exposure, she has found no reason to alter the opinion expressed in a previous paper, that although the time of irradiation required to produce tint B had varied from ten to ninety minutes, the resulting epilation in every case followed the same normal course, whether after a long or short exposure. No relationship was found between the atmospheric conditions and the time necessary for obtaining the B tint, and the readings of the voltmeter, ampèremeter, milli-ampèremeter, Benoist radio-chromometer, spark-gap, and pastille appeared to be quite independent of the weather. In answer to the question, Is there any constant relationship between the time required for the epilation dose and the penetration of the rays from a given tube as measured by the Benoist radio-chromometer? the author replies that there was apparently some relationship, but this was by no means constant. When the Benoist reading is as low as No. 2 or 3 the time required for the epilation dose is very long, and an attempt to hasten matters by increasing the voltage and ampèrage results in a still softer tube with a blue reverse current. On the other hand, as rapid results were obtained with a reading of 4 or 5 as with 6 to 8 Benoist.

With a given tube and apparatus, and the same voltage, ampèrage and milli-ampèrage, is the Benoist reading also always the same, and is the time required to obtain the pastille tint always the same, so that one can dispense with the use of the pastille after once determining this time? The answer to Belot's statement that "for a given tube, a given current and voltage always produce the same quality of rays," is that this is sometimes true but is not invariably the case, especially when a coil is used as the source of electrical energy. Tables are given to show that even when the voltage and milli-ampèrage are alike the Benoist readings may differ, and that when voltage, ampèrage, milli-ampèrage and Benoist readings all correspond, the time required for the pastille to alter may vary, *i. e.* the quantity of X-rays emitted may vary even when all the electrical constants are the same. (The variation in the tables is very remarkable, and according to the writer's view was not explained by the absence of a spark-gap rectifier or other means of excluding the reverse current during the first seven months, as during the second seven months a spark-gap rectifier was constantly in use and the variations in the reading were quite as marked as before).

The last question which the writer sets herself to answer is whether there is any constant relationship between the time of exposure necessary for the epilation dose and the time that elapses between the application and the falling of the hair. The reply is in the negative. We should prefer to attribute the delayed and incomplete hair-fall after protracted exposures (three quarters of an hour or more) to excess of caution on the part of the operator rather than to exhaustion of her patience. Our impression is that epilation is delayed and incomplete when an insufficient dose has been given, whether the exposure be a long or a short one. But this does not impugn the accuracy of the pastille, which, as the writer's careful observations show, can be trusted with both long and short exposures. This additional evidence for the trustworthiness of the pastille under all circumstances will be welcomed by X-ray workers. But a little more about the final results obtained in the cases treated would have added to the value of the paper.

S. E. D.

RECENT PROGRESS IN RÖNTGENOLOGY. D. Belot. (*Archives of the Röntgen Ray*, p. 344.) Official Report of the International Congress of Physio-therapy. Rome, 1907. Translated by A. Howard Pirie, M.D.

In the first part of this paper the writer deals with the value of röntgenoscopy and with the criticisms which have recently attributed exaggerated dangers to screen examinations. In thousands of examinations he has never seen the slightest accident to a patient, and the only precaution needed is not to expose the patient too long to the action of the rays. Protective apparatus has been introduced, and the chronic dermatitis of the operator is now rarely seen unless dating from injury received in the early days of röntgenography, when sufficient protection was not used. An arrangement by means of which the tube is covered is preferable to the protecting cabinets used in Germany. In the section devoted to apparatus the writer first refers to the static machine. In his opinion this is a very capricious generator and irregular in its output, and is losing its adherents day by day. The Rumkoff coil is the oldest and most widely used type, and has been much improved during recent years. The Blondel-Gaiffe "autonome" turbine interrupter can be used for instantaneous radiography or for ordinary work, and is certainly the best in France. With regard to tubes, which in recent years have been improved by the adoption of vacuum regulators, the simplest and most perfect is the osmo-regulator of Villard; the capacity of gas-holding regulators is soon reduced. Over-heating of the anode has given rise to the adoption of iridium and platinum (tantalum is not mentioned), or to reinforcement of the anti-cathode by blocks of metal. Other tubes with the source of rays at their extremity for introduction into cavities are fragile and are not recommended. Of the various instruments used for the purpose of measuring the current passing through the tube, reference is made to the milli-ampèremeter and to a static voltmeter recently constructed to measure the difference of potential between the anode and cathode. The radio-chromometer of Benoist and the chromo-radiometers of Holzknecht, Sabouraud, Kienböck and Freund, for the measurement of the quality and quantity respectively of the rays emitted from the tube are also discussed. Reference is made to the apparatus recently brought out by Dr. Luraschi, of Milan, which is based on the alteration of the resistance of a selenium cell irradiated by the X-rays, but which has not yet reached perfection. (We may mention that a well-known English worker has constructed a radiometer based on this principle more than three years ago.) Another method is the measurement of the ionization produced by the rays.

Technique has been greatly modified owing to more exact methods of dosage, and the method of giving a short exposure every day until reaction appears is losing its last supporters. An important point to be considered in the therapeutic application of X-rays is the great absorptive power of the skin and the rapid diminution of absorption of the rays below the skin surface. The difficulty may be overcome by the use of very penetrating rays or by putting the source of X-rays at a considerable distance. Large tumours can be divided into areas and each part treated separately. In this way the neoplasm receives the X-rays from all sides, while each portion of the overlying skin receives only one irradiation (multipolar irradiation). Sensitising the tissues by the injection of

fluorescing salts such as eosine has no value since the secondary rays emitted by these bodies are not analogous to the primary rays, being transformed into ultra-violet radiations. It is not unreasonable to suppose, with Goldstein and Holzknecht, that Röntgen rays and radium rays ultimately become ultra-violet light of short wave length. Another method of sensitising the skin which the writer considers to have failed only because its application is so difficult, is that of injecting a body of high atomic weight, such as a non-caustic iron salt; the secondary rays given off by the iron molecules are softer than the primary rays, and are therefore more easily absorbed by the morbid cells.

The writer then deals with some of the more important points in therapeutics. X-rays have revolutionised the treatment of Tinea tonsurans, furnishing a certain and rapid cure in a hitherto rebellious affection.

Incontestable results are obtained in a variety of skin-affections, among which psoriasis, acne, chronic eczema, keloid, pruritus, and lichen are mentioned. As a rule it is advisable to try other remedies first, and to have recourse to radio-therapeutics when these have failed. Under the influence of X-rays pruritus disappears and the tumours of mycosis melt away. The author has published a case of the latter disease which has remained cured after the lapse of several years. Nodular leprosy is favourably influenced, but X-rays only occasionally cure Lupus vulgaris. In cases of extensive or turgescent lupus, they are, however, of great value in preparing the ground for operation. Usually radio-therapy leads to a more or less rapid improvement. Then follows a period in which the lesion appears to remain stationary and the resistant nodules must be treated by other methods. The treatment of lupus, perhaps more than that of any other disease, necessitates a long experience on the part of the operator, and one method must be replaced by another—in fact a mixed treatment should be carried out. In the treatment of neoplasms radio-therapy indisputably gives the best success. It is the ideal method for cutaneous epithelioma: a cure is the rule and a failure the exception, provided that the lesions have not penetrated the deeper tissues. Where, however, the neoplasm is undergoing rapid evolution, the focus tube must yield to the knife. In cancer of a mucous membrane satisfactory results are only obtained in very early stages. Surgical intervention is usually necessary, but this should be succeeded by a course of X-ray treatment. In the case of cutaneous or subcutaneous recurrences after removal of the breast, careful irradiation is followed by remarkable amelioration and cure, at all events of the local lesion. On the other hand, the method is usually powerless against deep-seated cancerous lesions. Neoplasms of vasculo-connective tissue, sarcoma in particular, exhibit a surprising sensibility to the X-rays, and the writer has seen enormous sarcomas, deeply situated in the mediastinum and quite inoperable, entirely disappear with methodical X-ray treatment. It is hoped that all surgical intervention will in future be followed by careful X-ray treatment. It should be begun on the bleeding surface before the closure of the wound. If this is impossible, radiation should be commenced some days later through the dressing.

The numerous and striking results obtained in the treatment of leukæmia and adenopathies are alluded to, the results obtained being more constant, more regular, and more durable in leukæmia of the myeloid type than in the lymphatic type, and very irregular in non-leukæmic adenopathy. The writer concludes by

testifying to the therapeutic value of X-rays, for which he prophecies a great future. X-ray treatment when well carried out presents no danger. If it is often powerless against cancer, it is also powerless to produce a general metastasis, as has been asserted by certain authors. Thanks to the measuring instruments which we now possess X-ray treatment has become an exact science. One need no longer fear the terrible burns which were at one time far too common, and whose spectre still haunts the imagination of the public.

S. E. D.

MERCURY, SULPHUR, MERCURIAL POISONING AND SYPHILIS. Respighi. (*l'Idrologio, la climatologia e la Terapia fisica*, 1908.)

This is an investigation to show the part which sulphur waters play in the treatment of syphilis. After discussing the previous work done on the subject the author goes on to describe his own experiments. These include both experiments conducted *in vitro* and investigations on animals.

Treating the albuminate of mercury produced by the action of mercuric chloride on albumen with various sulphur compounds, he finds that when he uses either sulphuretted hydrogen or an alkaline sulphide, mercuric sulphide is formed, either as a precipitate, or in a state of colloidal solution; using sulphites or hyposulphites, the sulphite or alkaline sulphite of mercury is obtained in a true solution. On the other hand, if an excess of albuminous solution be added to the precipitate of albuminate of mercury, the latter diffuses itself so finely that the liquid becomes macroscopically clear. Treated with chloride, bromides, and alkaline iodides the albuminate gives rise to truly soluble compounds. The author shows also that colloidal mercuric sulphide is formed in animal tissues impregnated with a mercurial salt.

Next, animal experiments carried out by the author show that the sulphide is the least toxic salt of mercury, and that the chloride of mercury, when associated with the sulphide, loses some of its toxicity. The various compounds were administered in every possible way, *i. e.* by the mouth and also by subcutaneous, endo-peritoneal, and intra-venous injection. These results correspond with Professor Sabatani's, who has done experiments in which he found that, when what would otherwise have been a fatal dose of mercuric chloride was injected into an animal, if an injection of a sulphide was subsequently given, the animal survived.

What, then, is the *rôle* of the sulphides in therapeutics? It is to reduce the mercury to the form of the sulphide, the most inert form. This view is borne out by the clinical observations reported from the spas; for example, from Bareges. Uriages, etc., and of the cure of many cases of mercurial stomatitis by the use of sulphur waters. Further, at Uriages, during five years, no case of mercurial stomatitis has arisen *de novo* in patients under treatment there. The conclusion then to be drawn is that the *rôle* of sulphur in syphilis is secondary but important, *i. e.* to neutralise the toxic effects of the mercury and to prevent the occurrence of "ultra-therapeutic" phenomena.

A bibliography of the subject is appended.

H. D.

ON GRANULOMA TRICHOPHYTICUM, MAJOCCHI. Guiseppe Mazza. (*Archiv f. Derm. u. Syph.*, September, 1907, lxxxvii, p. 25.)

In this contribution the author describes in detail a case of ringworm of the

scalp in a girl, aged 12 years, due to a trichophyton, and associated with extensive tumid granulomatous lesions without suppuration. The lesions had a "boggy" consistence, and on puncture exuded a serous fluid. The surface of the lesions was studded with short stumps, which, on microscopical examination, showed chains of a large-spored fungus, forming reddish-violet colonies on cultivation Sections of the tissue were examined, and showed a granuloma made up of plasma cells and lymphocytes, with a few giant cells and mast cells. The granuloma was associated with marked œdema and a destruction of the elastic tissue. Several inoculation experiments were carried out, both in man and various animals, subcutaneous inoculations being made of the violet culture, but all of them gave negative results.

The writer considered that the "Granuloma trichophyticum Majocchi" is the direct result of the presence and action of the trichophyton, and that the ordinary acute suppurating kerion is the same condition, secondarily inoculated with pus organisms or caused to suppurate by chemical irritation.

J. M. H. M.

ON A SPIROCHÆTE FOUND IN VARIOLA. K. Sakurane. (*Japan. Zeitschr. f. Derm. u. Urologie*, February, 1908, viii, p. 20.)

At the Medical Society at Osaka in May, 1907, Sakurane described a case of smallpox in a man, aged 26 years, in which he had found a spirochæte. The patient had never had syphilis. Mature smallpox lesions were excised and sections cut and stained by Leviditi's method, and spirochætes were detected in the necrotic tissue, the deeper epidermis, and the papillæ. The spirochætes were somewhat similar to the *S. pallida* of syphilis. The author does not think it was an instance of smallpox occurring in a syphilitic, nor does he assert that the spirochæte is the cause of the smallpox.

J. M. H. M.

A CASE OF GENERALISED VACCINIA, WITH REMARKS ON THE PATHOLOGY OF THE DISEASE. R. S. Oldham. (*Dublin Journ. of Med. Sci.*, July 1st, 1908.)

The patient was a healthy female child, born on February 16th, 1907, and vaccinated with the contents of a single glass capillary tube of glycerinated calf-lymph obtained fresh from a well-known and reliable firm. The following is a chronological summary of events by the author:

First week (March 9th, 1907).—Vaccination.

First week (March 14th).—Inspection. Four healthy vesicles, to all appearance normal.

Second week (March 16th).—One or two supernumerary pocks present.

Second week (March 18th).—The four pocks enlarged and covered with dark brown scab. A great number of secondary pocks, at first vesicular, found round points of inoculation.

Second week (March 19th).—Innumerable secondary pocks round insertions, some vesicular, others pustular, forming a confluent mass. Areola extensive. A large pock appeared on back of head; another on buttock.

Second week (March 20th).—Pocks on forearm, wrist, and right buttock. (Pocks appeared on ankles, wrists, instep, back of neck, occiput and ala nasi.)

Third week (March 23rd).—Arm very red and brawny; glands in axilla much

swollen. Points of insertion very black, depressed, and gangrenous looking, in the midst of a general greenish-grey scab, which discharged a puriform fluid. Pustules on the outskirts confluent. Moist boric lint applied to arm.

Third week (March 24th).—Areola much less; discharge still continues. Pocks on body umbilicated and shrunken.

Third week (March 26th).—Discharge greatly lessened. Involution of other pocks continuing normally.

Fourth week (March 30th).—Condition much improved.

Fourth week (April 1st).—Whole arm cleared up except for original insertions, which remain as healthy ulcers. Pocks on body scabbed or separated.

Fourth week (April 2nd).—Mother's breast inoculated (? from suckling the child). Pock ran a normal course. Mother had not been re-vaccinated.

Seventh week (April 20th).—Child completely recovered.

The facts that the first pock appeared on the heel, that the vaccinated arm was kept covered by a dressing, and that care was taken to prevent contamination, strongly suggest to the writer that the case was one of generalised vaccinia, and that the lesions were not simply the result of accidental inoculation. The most remarkable feature of the case, however, is the absence of fever. The author suggests as a possible explanation of this the age factor, for it is believed that the constitutional disturbance is less in infancy than in later childhood.

J. M. H. M.

TERTIARY YAWS. R. Howard. (*Journ. f. Trop. Med. and Hygiene*, July 1st, 1908, p. 197.)

The fact of lesions, somewhat similar in type to the gummatous and ulcerating lesions of syphilis, occurring in the subjects of yaws, has been from time to time cited as an argument in favour of the identity of syphilis and yaws; and it has been asserted that the occurrence of late tertiary symptoms in a yaws patient must be attributed to a previous attack of syphilis. Other observers, however, maintain that yaws has a true tertiary stage with manifestations practically indistinguishable from those of syphilis, such, for example, as Daniels, who observed tertiary yaws in Fiji, and in this he has the support of the writer. Howard's experience was obtained from nine years' residence in Central Africa in the country bordering on the southern half of Lake Nyassa. There yaws, called "magangau," "abubwa," or "vyangalala" by the natives, is a common disease, while syphilis is rare and was only found in the large centres on the line of communication of slave caravans and which had frequent communication with the Arabs of the coast. The fact that syphilis does not spread more widely seemed to the author to indicate that yaws exerted a protective influence against it. Tertiary lesions of yaws came on after a varying period of perfect health of from two to twenty years. In two boys of about thirteen years of age, treated for undoubted yaws, tertiary lesions occurred in two and two and a half years respectively. These tertiary lesions consisted of:—

(1) Ulceration, which may be superficial or deep in type, the deeper ulcerations leaving thick scars and frequently causing contraction and deformity. The ulcers present irregular sinuous edges which tend to be undermined. Occasionally subcutaneous gummata giving rise to deep, clean-cut ulcers were noted.

(2) Diseases of bones and joints, chronic synovitis, nodules due to localised

periostitis. These nodules may suppurate and lead to caries and chronic sinuses. Diffuse osteitis has also been observed, and pain of a deep boring character is a pre-eminent symptom.

(3) Destructive ulceration of the nose, palate, and pharynx. This is very common. It may become arrested and heal spontaneously, or it may spread and cause total destruction of the bones, of the nose, perforation of the palate, and loss of pre-maxilla and incisor teeth.

In the majority of these tertiary yaws the administration of iodide of potassium causes rapid amelioration.

J. M. H. M.

UNIVERSAL DERMATITIS OF CHILDREN AT THE BREAST. Carl Leiner. (*Brit. Journ. Child. Dis.*, June, 1908, p. 244.)

In this contribution the author draws attention to a form of dermatitis in infants which he believes to be different from the Dermatitis exfoliativa of Ritter, eczema, etc. During the last five years he has observed 43 cases of it in the Carolinen Children's Hospital in Vienna. Of these 41 were in children nourished at the breast and 2 with the bottle; 28 were cured, and 15 died from the disease. As a rule the children are seen when the disease is at its height, about the end of the second month, and present the following appearances:

The scalp is usually covered with fatty scales and crusts, as in seborrhœa. The face is slightly inflamed and covered with thin yellow scales, except, as a rule, the nose. The trunk is intensely red and covered with greyish opaque scales. The limbs are similarly affected, especially the extensor aspects. The hands and feet are red in circumscribed spots. The nails are opaque, ridged and deformed, and raised up from the nail-beds by a horny mass. In the flexor aspects of the joints the skin is red and œdematous. The internal organs, except the digestive organs, are not affected, the glands are only slightly swollen, and the general health of the child is not interfered with, and there is no retching. In most cases the digestion is impaired. As a rule the cases run a benign course, and the disease is cured in a few weeks. In about a third of the cases in spite of continuing the breast feeding intestinal symptoms supervene with severe diarrhœa. The child becomes wasted, fever sets in, and death results. Post-mortem examinations have revealed degeneration of the heart and liver, and catarrhal changes of the intestinal mucosa.

Bacteriological examination of the scales showed the presence of *Staphylococcus albus*, more rarely *S. aureus*, *Bacillus pseudo-diphtheriæ*, and *B. pyocyaneus*. The author did not consider that any of these were of causal importance. Nor did he consider it to be a septic dermatitis. He believed it to be an auto-toxic erythema, probably connected with the intestinal troubles which were always present. The author discusses in detail the diagnosis of these affections from Dermatitis exfoliativa of Ritter and eczema. In Ritter's disease the affection begins with a redness round the mouth, whence it spreads over the entire body. This is followed by slight exfoliation, which becomes more marked till the skin is covered with scales and crusts. The disease runs an acute course, seven to ten days. These characteristics are absent in the affections described by Leiner.

J. M. H. M.

ON THE VALUE OF THE OPHTHALMO-REACTION IN THE DIAGNOSIS OF TUBERCULOSIS. Sinclair Gillies. (*Austral. Med. Gaz.*, May 20th, 1908, p. 216.)

In this contribution there is a record of a series of observations made with the object of testing the diagnostic value of the reaction. In these observations either Calmette's serum or a serum made by precipitating old tuberculin with absolute alcohol, washing carefully, drying, and then making a 1 per cent. solution from the precipitate. In all 129 tests were made in 103 patients, the tests being controlled, where any doubt had arisen, by the injection of old tuberculin. The two eyes were carefully compared before the test, and when one conjunctiva appeared redder than the other the paler eye was the one tested. The reactions appeared in from two and a half to eighteen hours, and as far as could be judged bore no relation to the extent or site of the disease. In no case were any ill effects produced by one installation, and the number of severe reactions was small and occurred mostly in children. Of the primary installations fifty-three cases gave positive and fifty negative results, but of the fifty negative cases thirty-nine were definitely non-tubercular, four were old cases of tuberculosis which had healed, one was a case of probable tubercular meningitis.

Various other diseases were tested, such as enteric and syphilis. Out of twelve cases of convalescent enteric apparently free from tuberculosis, two reacted, and out of seventeen cases of secondary syphilis three gave a positive reaction. In a number of cases a second inoculation was made where the primary installation had failed, and it was found that a reaction was much more liable to occur if the second inoculation was made seven days or longer after the primary one. An interesting point which was several times noted was that subcutaneous injection of tuberculin as a confirmatory test caused a marked recrudescence of the ophthalmo-reaction.

As a result of their observations the writer draws the following conclusions:

(1) A positive ophthalmo-reaction with 1 per cent. Calmette's tuberculin, in the absence of secondary syphilis, and possibly convalescent enteric fever, is diagnostic of the presence of an active or recently quiescent tubercular focus sowewhere in the body.

(2) A negative reaction does not definitely exclude tuberculosis, but is strongly against its presence, the margin of error being about 13 per cent.

(3) The ophthalmo-reaction is as reliable as the ordinary tuberculin reaction, is readily carried out, involves little discomfort and no loss of working time to the patient.

(4) The reaction is of no value unless it is certain that the eye has not been previously tested.

(5) Where the original reaction has been negative it may be repeated within eight days and a positive result accepted.

(6) Where doubt exists as to the correctness of the reaction, confirmatory injection, if done, should be performed within eight days where the reaction has been negative and five where positive.

J. M. H. M.

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